

Evidence Summary

Parent Training Programs

What Are Parent Training Programs?

Parent training programs, sometimes called parent-management training (Pearl, 2009), consist of integrated and manualized interventions designed to enable parents to acquire parenting skills to influence and manage their children's behavior at home. Programs may also address the child's physical health or the parent's mental health. However, the primary aim of parent-training programs is the *training* of parents to manage their children's *behavior*, rather than educating parents about their children or changing child behavior without parental involvement.

The Need for Parent Training Programs

In 2013, more than 5 percent of U.S. children ages 4–17 had serious problems with concentration, behavior, emotions, and ability to relate to others, according to parental reports (Federal Interagency Forum on Child and Family Statistics, 2015). Nearly 10–30 percent of the 20 million American children under age 5 had significant impairment in their social relationships and school functioning, due to severe behavioral problems (Gross et al., 2014). In addition, 679,000 children were found to be victims of abuse and neglect, and 91.4 percent of the perpetrators were one or both of the child's parents (Child Welfare Gateway, 2015).

Statistics about child behavioral problems and child maltreatment represent major public health concerns (Stronach, Toth, Rogosch, & Cicchetti, 2013; Wilson et al., 2012). They are also costly problems that have a long-term impact on the health of children, families, and society. (Gross et al., 2014). Maltreated children are at high risk for disorganized attachments, resulting in poor peer relationships and difficulty regulating emotions (Sroufe, Egeland, Carlson, & Collins, 2005). Children who have problems with aggression, affect regulation, and oppositional behaviors are at similar risk for school failure, school dropout, and eventual delinquency. In addition, child disruptive behavior problems are linked to antisocial behaviors later in life (Webster-Stratton, Reid, & Stoolmiller, 2008).

As awareness of these public health issues has grown, a wide variety of parent training programs have been created to address the emotional needs of parents and the behavioral difficulties of their children (Kaminski, Valle, Filene, & Boyle, 2008).

Historical Background

Prior to the late 1960s, problematic behaviors among children were addressed through individual child psychotherapy, institutionalization of children and adolescents, or juvenile detention (Kaminski et al., 2008). Attention was placed solely on changing the child's disruptive behavior. A paradigm shift after the 1960s led to the recognition that the parent-child

relationship has a major influence on the child's behavior or misbehavior. Child clinicians began to realize that changing the parent's behavior could change the child's behavior. Further, parents intervening with their own children, rather than clinicians working solely with the child, yielded more positive outcomes for changing child behaviors (Kaminski et al., 2008). As an outgrowth of this realization, the development of parent training programs began to proliferate in the United States and internationally. As noted by Breitenstein and colleagues (2012), parent training began to be considered a "gold standard" for the treatment and prevention of young children's behavioral problems.

Design of Current Programs

Most parent training programs are based on theories about child development and how children learn. Many well-known programs are grounded in cognitive learning theory (Bandura, 1989) and the behavioral theory of operant conditioning (Skinner, Zimmer-Gembeck, & Connel, 1998). Parents are taught principles of positive reinforcement (e.g., praise and rewards) for behaviors that promote social acceptance; they learn to replace harsh punishment with more effective forms of discipline to decrease negative, challenging behaviors (Pearl, 2009). Some programs integrate family systems theory and attachment theory into principles about learning, thereby creating a multi-theoretical approach. These programs aim to enhance parent-child relationship quality and promote sensitive parental behaviors linked to the child's attachment security (Berlin, Shanahan, & Carmody, 2014; Stronach et al., 2013).

Regardless of the theoretical framework, the central focus of all parenting programs is family functioning and its effect on child development. According to Pearl (2009), "The hypothesis that a child's noncompliance is shaped and maintained through maladaptive patterns of family interaction guides many of the goals for treatment" (p. 297). Similarly, the screening and referral process, emphasis on prevention, and techniques of intervention are comparable across all models of parent training.

Screening and Referral Process

Most parents and children are referred to parent training programs through school settings or through medical and mental health professionals (Kaminski et al., 2008; Pearl, 2009). These referrals are triggered by the perceived cognitive, emotional, and physical needs of the children. Some programs are targeted for children who have specific problems, including academic difficulties; problems with delinquency, conduct disorder, and oppositional defiant disorder; challenges with peer relationships; and adjustment to trauma or divorce. Some parents join parent training programs voluntarily, in response to recruitment through the media, which highlight particular behavioral or medical issues of children, such as attention deficit hyperactivity disorder or cerebral palsy.

Other referrals are based on the specific needs of the parents, such as those who have mental health or substance abuse issues and families at risk or who are under investigation for child maltreatment. Parent training is especially common among parents receiving child welfare services. More than 400,000 individuals a year are mandated or volunteer to attend parent training to reunify or preserve their families (Barth et al., 2006). Other parents may be referred to parent training due to socioeconomic challenges or the experience of domestic violence, though they are not receiving child welfare services.

Prevention

Most parent training programs have been developed with the goal of prevention in mind. In particular, parent training has been created for the families of preschool age children to increase school readiness and prevent the development of future conduct disorders (Webster-Stratton, Reid, & Stoolmiller, 2008). Parent training has been integrated into comprehensive programs designed to reduce the behavioral risk of children in low-income neighborhoods (Gross et al., 2009). Other training programs have been developed for high-risk parents of newborns, such as new mothers in recovery, to prevent emotional problems in infants through increasing the nurturing capacity of their mothers (Berlin et al., 2014). Designed for both children and parents, a number of prevention programs target elementary school-age children and young adolescents at risk for substance abuse.

Parent Training Program Components

Most parent training programs combine didactic information with skills training, emphasizing positive parental communication, consistent behavioral management, and awareness of the cognitive and emotional development of the child (Kaminski et al., 2008; Sanders et al., 2012). Programs often include individual parent-clinician support, large and small group work, role plays, videos, Internet activities, and homework, with attention given to active, rather than passive learning. Many training programs require parents to practice communication strategies with their children, while under the observation of a clinical facilitator who provides feedback and professional coaching (Barnett, Niec, & Acevedo-Polakovich, 2014).

Webster-Stratton and Taylor (2001) maintain that it is critical that all interventions be delivered in the context of an empathetic relationship between the clinician and parent, demonstrating an understanding of the challenges of parenting a child with serious behavior problems. They note that the clinician “must be an effective ‘coach,’ sometimes educating, sometimes cheering on and encouraging parents to stick with it, and sometimes problem-solving difficult issues and exploring resistance, all with a high level of sensitivity, compassion, and understanding of child development principles” (p. 171).

The setting for service delivery can occur in a variety of locations, including the parent’s home, community-based group settings, the school classroom, outpatient clinics, in-patient hospital settings, online, and even in prisons and substance abuse recovery centers (Berlin et al., 2014; Kaminski et al., 2008).

Highlights of Effective Programs

The current number of parent training programs is unknown because many have not been evaluated and outcomes of their effectiveness have not been published. However, there are 78 “parent-training” programs currently listed in the Substance Abuse and Mental Health Administration’s (SAMHSA’s) National Registry of Evidence-based Programs and Practices (NREPP). NREPP (SAMHSA, 2015) includes interventions for children ages 0–17 and their parents. Among these interventions, three are replicated programs that have been evaluated through numerous randomized controlled trials, partially or fully funded by the National

Institutes of Health. The following is a brief description of these three highly effective programs, highlighting the similarities and differences of the interventions.

Parent Management Training (PMT) – Oregon Model

The Parent Management Training (PMT) program (Forgatch & Martinez, 1999) was developed in the 1960s at the University of Oregon and is based on social learning principles and Patterson and Guillion's (1968) book, *Living With Children*. This training model focuses on changing the internalizing and externalizing behaviors of the child, delinquency, academic functioning, and the child's noncompliance with the mother's directives. Designed for parents of children ages 3–12, clinicians meet individually with parents in the parent's home for 10–17, 1-hour sessions. PMT teaches parents behavioral principles to help them modify their children's disruptive behavior through positively reinforcing more desirable behaviors. For example, parents are taught to praise their children's positive behaviors with statements such as "Thank you for listening," and to ignore undesirable behaviors, assuming the behaviors are not harmful or destructive (Pearl, 2009). According to the NREPP (SAMHSA, 2015), the PMT-Oregon Model has been evaluated as effective with multiple ethnic groups in the United States (American Indian/Alaska Native; black; Hispanic/Latino; and white).

The Incredible Years (IY)

Using a group-training format, the Incredible Years BASIC program (IY) was developed in Seattle, Washington, by Dr. Carolyn Webster-Stratton in 1992. The program has two parent versions, one for parents of preschool children (ages 2–6 years) and one for parents of early school-age children (ages 5–10) (Webster-Stratton & Taylor, 2001). The model follows a strengths-based approach, integrating cognitive-behavioral principles within a relational framework. Groups of 10–14 parents receive group support, led by one or two professional group leaders, in 2- to 2 ½ -hour sessions, over the course of 12–14 weeks. Parents are required to read Webster-Stratton's (1992) book, *The Incredible Years: A Troubleshooting Guide for Parents* and then watch brief video vignettes of parents and children interacting, while stopping to discuss each video. In addition to the video vignettes, there are checklists for each session, group-leader scripts, homework materials, practice activities, and "principles" to highlight (Pearl, 2009). IY includes a teacher program, as well as the parent program, and the IY series of programs is reported to have good outcomes with an ethnically diverse group of parents, including families who are American Indian /Alaska Native; Asian; black; Hispanic /Latino; and white (Pearl, 2009; SAMHSA, 2015).

Triple P – Positive Parenting Program

Dr. Matthew Sanders and colleagues at the University of Queensland in Australia created the Triple P-Positive Parenting Program in 1977 (Pearl, 2009; Triple P, n.d.). Similar to other parent-management-training programs, Triple P is based on social learning and developmental theories and focuses on the prevention and treatment of severe behavior and emotional problems in children, ages 0–12. One distinctive feature of Triple P is that it provides a tiered, five-level system of treatment, based on the severity of the child's dysfunction and need for family support. Further, it offers varied delivery formats, including small- and large-group, individual and self-directed, and through media and online interventions (Sanders et al., 2012). Triple P has been implemented in the United States and internationally, for the prevention and treatment of children with conduct disorders.

The Triple-P program is also being or has been adopted by cities and counties around the world as an educational and preventive means of addressing problems within a whole population (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009). In the United States, Triple P has been implemented in South Carolina, with the aim of preventing child maltreatment on a statewide population level. That is, 18 counties in the state were randomly assigned to receive Triple P services, rather than referring individual parents or children based on the specific behavioral problems of the children (Prinz et al., 2009).

Effectiveness of Parent Training Programs

With the expansion of parenting programs, emphasis on evaluating program effectiveness has intensified. Hundreds of empirical studies have been conducted, and large meta-analyses of the research support the effectiveness of a variety of manualized training programs. Overall, the outcomes of these studies suggest that parent training programs generally have positive effects on changing the behavior of both the child and the parent (Baumann et al., 2015; Kaminski et al., 2008; Pearl, 2009; Sanders et al., 2012; Wilson et al., 2012). According to Forgatch and colleagues (2013), there now exists a large set of parent-training interventions for both children and adolescents, which are supported empirically. At the same time, however, the evidence does not uniformly support the effectiveness of parent training programs.

Kaminski and colleagues (2008) conducted a meta-analysis of 77 parent training programs and found four key components in programs with the most robust positive effects. These components were 1) teaching consistent discipline, 2) providing emotionally positive and enthusiastic responses for appropriate behavior, 3) interacting on the child's level during play, and 4) supporting the child in taking the lead while playing. This review showed that children ages 0–7 who had externalizing behaviors had more positive effects from parent trainings that emphasized positive parent–child interactions and emotional communication, rather than problem-solving or cognitive, academic, and social skills. It was also important for parents to practice with their children while clinical facilitators observed and gave feedback.

An extensive systematic review of 13 clinical trials of parent training programs enabled Furlong and colleagues (2011) to distinguish between the types of outcomes measured, particularly when service delivery was through group-based programs. They concluded that behavioral and cognitive-behavioral “group based parenting interventions appear to be effective in reducing child conduct problems and in improving parenting skills and parental mental health” (p. 62); however, they went on to state that there was an insufficiency of information on the efficacy of these programs in regard to children's emotional problems and cognitive or educational abilities.

The three previously discussed programs – PMT, IY, and Triple P – have received particularly high marks for their effectiveness. PMT has been “evaluated in scores of randomized controlled outcome trials with children,” and these studies have “produced some of the most impressive research results on treatment efficacy of disruptive behavior disorders” (Pearl, 2009, p. 296). Several systematic reviews have shown that PMT is associated with significant improvements in child disruptive behavior, compared with control conditions (Michelson, Davenport, Dretzke, Barlow, & Day, 2013). Likewise, evidence from numerous randomized controlled trials

of the IY program suggest that children whose parents participate in IY have significantly fewer conduct problems, compared with controls. Further, outcomes are maintained long term, and benefits are extended to children with socioeconomic disadvantages (Pearl, 2009; Webster-Stratton et al., 2008).

Evidence on Triple P

Evidence for Triple-P's effectiveness is based on more than 200 publications, numerous published randomized controlled trials, and four meta-analyses of the body of research (Wilson et al., 2012). As creators of the program, Sanders and colleagues (2012) point to an evidence base that has continued to evolve and grow over a period of 30 years.

Triple P's implementation as a prevention strategy in South Carolina represented the first time a program was evaluated in the United States through the randomization of geographic areas (Prinz et al., 2009). Considered a population-based form of evaluation, the outcome of the study showed the training had a positive impact on reducing child maltreatment in the communities that were served. Substantiated cases of child maltreatment, out-of-home placements into foster care, and injuries due to child maltreatment were fewer in the counties that received the Triple P interventions versus the control counties, after controlling for the size and poverty level of the counties.

Despite the robust body of research on the Triple P program and the implementation of the program at a population level, there has been debate regarding its effectiveness and the validity of some of the findings. Wilson and colleagues (2012) conducted a meta-analysis of 33 eligible studies and expressed concern about "the high risk of bias, poor reporting and potential conflicts of interest" (p. 1). They reportedly found "no convincing evidence that Triple P interventions work across the whole population or that any benefits are long-term" (p. 1). However, Sanders and colleagues (2012) refuted this finding, arguing that evaluation of this type of system is complex and that the differences in the type and intensity of the intervention have to be considered. However, Coyne and Kwakkenbos (2013) also found problems with the literature on the program and its "over-reliance on positive but substantially underpowered trials."

Evidence on Home-Based Interventions

In contrast to parent-group training, home-based interventions that are focused more directly on the parent-child relationship have received positive outcomes related to the child's emotional state. One such attachment-based intervention is Child-Parent Psychotherapy (CPP), a treatment for children, ages 0–5, who have been exposed to maltreatment or another form of trauma (SAMHSA, 2015). Similar to other parent training programs, CPP is highly rated by NREPP as an evidence-based treatment, but is listed as parent-child therapy, rather than parent training. The primary goal of CPP is to strengthen the relationship between the parent and child through helping the parent understand the trauma the child has experienced. Stronach and colleagues' (2013) investigation of home-based treatment with parents of maltreated children compared CPP with another psychoeducational parenting intervention, as well as with control groups receiving community standard treatment and with a group of non-maltreated children. Only children in the CPP group demonstrated sustained attachment security 12 months after completion of the program. The researchers suggest that maintaining secure attachment in

children over time might require more intensive intervention, such as CPP, rather than parent training alone.

Concerns about Evidence-Based Programs for Child Welfare Parents

Barth and colleagues (2005) have stated that child welfare must rely on parent training that is evidence based and effective, because “this is the primary intervention that child welfare agencies provide in trying to preserve or reunify families. Without effective interventions, there is no chance of operating an equitable child welfare system” (p. 354). However, the search for such programs is usually a long, slow process. Although judges routinely mandate parents to attend such programs, a 50–80 percent parent dropout rate has been reported (Barth et al., 2005). Barth et al. have encouraged child welfare agencies to refer parents to programs that have been empirically validated as effective in improving parenting.

In addition to high marks for The Incredible Years (Webster-Stratton et al., 2008) and Parent Management Training-Oregon Model (Forgatch & Martinez, 1999), they recommend Parent-Child Interaction Training (PCIT; Eyberg & Robinson, 1982) and Multisystemic Therapy (MST; Henggeler et al., 2003). Both PCIT and MST are considered by NREPP (SAMHSA, 2015) to be evidence-based models of psychotherapy, rather than parent training programs.

Concerns about Effectiveness for Diverse Populations

The majority of parent training programs have been developed and empirically tested on populations of white, middle-class families (Gross et al., 2014). This factor is concerning since recent surveys report that 8 percent of 4–17 year olds with serious behavior problems live in poverty (Federal Interagency Forum on Child and Family Statistics, 2015). In addition, general population studies report that, in 2013, 20 percent of U.S. children ages 0–17 lived in poverty. Of these children, 39 percent were black, non-Hispanic; 30 percent were Hispanic; and 11 percent were white, highlighting the significant racial and ethnic disparities among children in poverty (Gross et al., 2014). Although “socioeconomic disadvantage does not necessarily lead to social and emotional outcomes,” low income is “a significant risk factor for the early onset of conduct problems and academic underachievement” (Webster-Stratton et al., 2008, p. 471).

Recently, parent training programs have been designed or modified to focus on low-income families and specific underserved populations. The Chicago Parent Program (CPP; Gross et al., 2009), for example, was developed through collaboration with African American and Latino parents to address the needs of these specific populations in urban Chicago. Other existing program protocols, such as the Incredible Years Program (Webster-Stratton et al., 2008), have been modified and redesigned to address the cultural differences of new populations in need of service. Despite efforts to be attuned to shifting societal demographics, however, Gross and colleagues (2014) have found that there is a dearth of evidence-based, parent-training interventions for low-income, underserved racial and ethnic populations.

Conclusion: The Challenges of Implementation

Although a large and growing body of empirically supported parent training programs exists, focused on children from birth through young adulthood, the contemporary challenge is the implementation of these programs. Parent training programs “hold the promise of reducing the

prevalence of child and adolescent behavior problems, maltreatment and related poor outcomes,” but “these programs remain largely unavailable to families seeking help in community agencies” (Forgatch, Patterson, & Gewirtz, 2013. p. 682). Implementing an empirically supported intervention into routine practice is complicated and requires leadership and commitment from a strong individual, group, and community to make the plan materialize. There are numerous stages along the way before a program can be implemented in a sustainable way (Forgatch et al., 2013; Rogers, 1995), demonstrated by the years of planning between the creation and eventual acceptance of programs such as Parent Management Training, the Incredible Years, and Triple P-Positive Parenting Program.

Part of the challenge is surviving the cost-benefit analysis of implementing these training programs. Gross and colleagues (2014) have suggested that parent training programs are cost-effective because of the long-term costs to society of children who have untreated behavior problems. They report that the annual public costs of child behavior problems in the United States can range from \$24,000 to \$61,000 per child, due to services needed (e.g., mental health, special education or grade retention, and involvement in the juvenile justice system).

Furlong and colleagues (2012) note that few randomized studies include cost studies to facilitate a cost-benefit analysis. However, their systematic review of the Incredible Years parenting programs, which included two studies with cost analyses, indicates that the value of the potential benefits of the program far outweigh its delivery costs, as it reduces the level of conduct problems from clinical to non-clinical and offsets the long-term legal, social, and health costs that are associated with this disorder.

A final question is whether a population approach to the public health concerns of child maltreatment and child behavior disorders is the most cost-effective means of implementing parent training. Prinz and colleagues (2009) caution that Triple P’s success in South Carolina “is not the equivalent of a parenting vaccine, where a single-shot exposure will afford continuing protection the population” (p. 9). Nevertheless, some who have reviewed the outcomes of this particular study believe that the cost of implementing the program may be offset by the money that is ultimately saved. (Wilson et al., 2014).

In sum, empirical research confirming the effectiveness of parent training programs for the treatment and prevention of child behavior problems is impressive. According to Forgatch and colleagues (2013), “We have completed the horse race epoch in which we established programs as evidence-based through careful assessment, sophisticated modeling, and replicated randomized controlled trials” (p. 14). But they also note the necessity of making the program accessible to all families in need. Thus, professionals implementing parent training programs must answer questions about cost-effectiveness, long-term sustainability, and cultural adaptations if these programs are to move successfully into the real world of clinical practice (Baumann et al., 2015; Michelson et al., 2013). Clinicians and agency administrators also must consider evidence about which form of parent training would work best in their communities, given the severity of the parent and child problems at both the individual and population levels.

References

- Bandura, A. (1989). Regulation of cognitive processes through perceived self-efficacy. *Developmental Psychology*, 25, 729–735.
- Barnett, M., Niec, L., & Acevedo-Polakovich, D. (2014). Assessing the key to effective coaching in parent-child interaction therapy: The therapist-parent interaction coding system. *Journal of Psychopathol Behav Assess*, 36(2), 211–223.
- Barth, R., Landsverk, J., Chamberlain, P., Reid, J., Rolls, J. Hurlburt, J., ...Kohl, P. (2005). Parent-training programs in child welfare services: Planning for a more evidence-based approach to serving biological parents. *Research on Social Work Practice*, 15, 353-371.
- Baumann, A., Powell, B., Kohl, P., Tabak, R., Penalba, V., Proctor, E., ...Cabassa, L. (2015). Cultural adaptation and implementation of evidence-based parent-training: A systematic review and critique of guiding evidence. *Children and Youth Services Review*, 53, 113–120.
- Berlin, L., Shanahan, M., & Carmody, K. (2014). Promoting supportive parenting in new mothers with substance-use problems: A pilot randomized trial of residential treatment plus an attachment-based parenting program. *Infant Mental Health*, 35(1), 81–85.
- Breitenstein, S., Gross, D., Fogg, L., Ridge, A., Garvey, C., Julion, W., & Tucker, S. (2012). The Chicago Parent Program: Comparing 1-year outcomes for African American and Latino parents of young children. *Research Nursing Health*, 35(5), 475–489.
- Child Welfare Gateway. (2015). *Child maltreatment 2013: Summary of key findings*. Washington, DC: U. S. Department of Health and Human Services, Children's Bureau.
- Coyne, J., & Kwakkenbos, L. (2013). Triple P-Positive Parenting programs: The folly of basing social policy on underpowered flawed studies. *BMC Medicine*, 11(11), 1–3.
- Eyberg, S., & Robinson, E. (1982). Parent-child interaction therapy: Effects on family functioning. *Journal of Clinical Child Psychology*, 11, 130–137.
- Federal Interagency Forum on Child and Family Statistics (2015). *America's children: Key national indicators of well-being, 2015*. Washington, DC: U.S. Government Printing Office. Retrieved from www.childstats.gov
- Forgatch, M., Patterson, G., & Gewirtz, A. (2013). Looking forward: The promise of widespread implementation of parent training programs. *Perspect Psychol Sci*, 8(6), 682–694.
- Forgatch, M., & Martinez, D. (1999). Parent management training: A program linking basic research and practical application. *Journal of Consulting and Clinical Psychology*, 67, 711–724.
- Furlong, M., McGilloway, S., Bywater, T., Hutchings, J., Smith, S., & Donnelly, M. (2012). Behavioural and cognitive-behavioural group-based parenting programmes for early-onset conduct problems in children age 3 to 12 years. *Campbell Systematic Reviews*, 12. Oslo, Norway: The Campbell Collaboration. doi: 10.4073/csr.2012.12
- Gross, D., Belcher, H., Ofonedu, M., Breitenstein, S., Frick, K., & Chakra, B. (2014). Study protocol for a comparative effectiveness trial of two parent training programs in a fee-for-service mental health clinic: Can we improve mental health services to low-income families? *Trials*, 15(70). doi:10.1186/1745-6215-15-70
- Gross, D., Garvey, C., Julion, W., Fogg, L., Tucker, S., & Mokros, H. (2009). Efficacy of the Chicago Parent Program with low-income African American and Latino parents of young children. *Prevention Science*, 10, 54–65.

- Henggeler, S., Rowland, M., Halliday-Boykins, C., Sheidow, A., Ward, D., Randall, J., ... Edwards, J. (2003). One-year follow-up of multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42, 543–551.
- Kaminski, J., Valle, L., Filene, J., & Boyle, C. (2008). A meta-analytic review of components associated with parent training program effectiveness. *Journal of Abnormal child Psychology*, 36, 567–589.
- Michelson, D., Davenport, C., Dretzke, J., Barlow, J., & Day, C. (2013). Do evidence-based interventions work when tested in the “real world?” A systematic review and meta-analysis of parent management training for the treatment of child disruptive behavior. *Clinical Child and Family Psychological Review*, 16, 18–34.
- Patterson, G. R., & Gullion, M. D. (1968). *Living with children: New methods for parents and teachers*. Champaign, IL: Research Press.
- Pearl, E. (2009). Parent management training for reducing oppositional and aggressive behavior in preschoolers. *Aggression and Violent Behavior*, 14, 295–305.
- Prinz, R., Sanders, M., Shapiro, C., Whitaker, D., & Lutzker, J. (2009). Population-based prevention of child maltreatment: The U.S. Triple P system population trial. *Prevention Science*, 10, 1–12.
- Rogers, E. (1995). *Diffusion of innovations* (4th ed.). New York, NY: Free Press.
- Sanders, M., Pickering, J., Kirby, J., Turner, K., Morawska, A., Mazzucchelli, T., Ralph, A., & Sofronoff, K. (2012). A commentary on evidenced-based parenting programs: Redressing misconceptions of the empirical support for Triple P. *BioMed Central*, 10, 145.
- Skinner, E.A., Zimmer-Gembeck, M.J., & Connel, J.P. (1998). Individual differences and the development of perceived control. *Monographs of the Society for Research in Child Development*, 63(2-3). Serial No. 254.
- Sroufe, A., Egeland, B., Carlson, E., & Collins, W. (2005). *The development of the person: The Minnesota study of risk and adaptation from birth to adulthood*. New York: Guilford.
- Stronach, E., Toth, S., Rogosch, F., & Cicchetti, D. (2013). Preventive interventions and sustained attachment security in maltreated children. *Developmental Psychopathology*, 25 (4 Pt. 1), 919–930.
- Substance Abuse and Mental Health Services Administration, National Registry of Evidence-based Programs and Practices. (2015). Retrieved from <http://www.nrepp.samhsa.gov/SearchResultsNew.aspx?s=b&q=parent%20training>
- Triple P (n.d.). *The Triple P – Positive Parenting Program: Small changes, big differences*. Retrieved from www.triplep.net.
- Webster-Stratton, C. (1990). *The incredible years: A trouble-shooting guide for parents of children ages 3-8 years*. Toronto: Umbrella Press.
- Webster-Stratton, C., Reid, J., & Stoolmiller, M. (2008). Preventing conduct problems and improving school readiness: Evaluation of the Incredible Years teacher and child training programs in high-risk schools. *Journal of Child Psychological Psychiatry*, 49(5), 471–488.
- Webster-Stratton, C., & Taylor, T. (2001). Nipping early risk factors in the bud: Preventing substance abuse, delinquency, and violence in adolescence through interventions targeted at young children (0-8 years). *Prevention Science*, 2(3), 165–192.
- Wilson, D., Hayes, S., Biglan, A., & Embry, D. (2014). Evolving the future: Toward a science of intentional change. *Behavioral and Brain Sciences*, 37, 395–460.

Wilson, D., Rush, R., Hussey, S., Puckering, C., Sim, F., Allely, C., Doku, P., McConnachie, A., & Gillberg, C. (2012). How evidence-based is an 'evidence-based parenting program? A PRISMA systematic review and meta-analysis of Triple P. *BioMed Central*, 10, 130, 1–16.

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